VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 10, 2014

Ms. Jeanne Schmelzenbach, Administrator
Loretto Home
59 Meadow Street
Rutland, VT 05701-3994

Provider #0138

Dear Ms. Schmelzenbach:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite complaint investigation conducted on **February 18, 2014.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

PRINTED: 03/03/2014
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0138	A. BUILDING: _____ B. WING _____	C 02/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LORETTO HOME	59 MEADOW STREET RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 2/18/14 by the Division of Licensing and Protection. There was a regulatory deficiency identified. The findings include;	R100	**R128 Resident Care and Home Services:** **Resident #1** On 02/20/14 the D.O.N. conducted a follow up investigation regarding Resident #1 medication documentation omissions. A complete summary of this report is available upon request. The D.O.N. identified six P.C.A. staff members and one L.P.N. where routine medications were not signed off as given. The staff members admitted to omitting documentation while maintaining confidence that they had administered the medications. On two occasions controlled substances were signed out in the narcotic book but not on the M.A.R., which supports this assumption. The D.O.N also noted that the Calcium 600 mg was accurately reported by the surveyor as not being documented, however, on 2/10, 2/11, 2/12, and 2/13 the medication should not have been given as there was an order to have the Calcium discontinued and the M.A.R. reflects this. Resident #1 is able to make her needs known to the staff and communicate personal choices to staff. All staff members involved have been counseled and two individuals are no longer on staff. Due to the errors that were identified, the organization immediately reviewed all processes and procedures; met with the employees and developed a few new standards of operations. They are as follows: On 02/25/2014 the D.O.N. and Administrator met with all P.C.A. staff and nursing staff members to review the importance of accurate Medication Administration and documentation.	02/25/14 2/25/14 & on-going
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that each resident's medication, treatment, and dietary services are consistent with the physician's orders for 3 of 6 residents reviewed (Resident #1, #2 and #3) The findings include; 1. Per medical record review, Resident #1 was admitted on 2/26/13 with diagnoses that include, anxiety, depression, diabetes, chronic back pain and personality disorder. Per review of the medication administration record for the month of February 2014, the following routine medications were noted to not have been signed off by staff that the medication was given to Resident #1 per physician's order to Resident #1. Calcium 600 mg with Vitamin D 200 mg at 8:00 PM on 2/4, 8, 10, 11, 12, 13.	R128		

R128 POC accepted 4/3/14 MeadhamRN/PMC

PMC

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R128	Continued From page 1 Glucophage 1 tablet (for diabetes) at 8:00 PM on 2/4 and 2/8. Neurontin 300 mg at 12 noon on 2/9 and at 8 PM on 2/13. Flexiril 10 mg (for pain) at 1 PM on 2/9 Melatonin 3 mg at 8 PM 2/11 and 2/15 Ultram 50 mg (for pain) at 6 PM on 2/10 Klonopin 1 mg at 8 PM on 2/4, 2/7 and 2/9 Novolog 12 units (for diabetes) at 8 AM on 2/14 and at 12 noon on 2/4 and 2/14. None of the following medications on the medication administration record were signed that they were given to Resident #1 on 2/11; Claritin, Cymbalta, Lasix, Zocor, Multivitamin, Aspirin, Magnesium Oxide, and Methadone. Per review of the medication administration record, the nurse's notes, the facility medication error reports and the physician's notes there was no evidence that Resident #1 had refused the medications, or any evidence that there was any reason that Resident #1 should not have received the listed medications as ordered by the physician on 1/28/14. Per review of the facility medication error reports for Resident #1, reports have been issued to nursing staff that pass medications to Resident #1 about not receiving medications on 11/2/13, 12/6/13, 12/8/13, and 2/8/14. Per review of the medical record, Resident #1 is able to make needs known to staff and	R128	We have initiated a daily auditing process per shift (please see attachment "A" M.A.R. and T.A.R Auditing Process and "B" M.A. R. Audit Sheet). The D.O.N. will monitor completed audit forms weekly to ensure the process is being followed. The D.O.N. will address all incomplete audit forms and will follow VCC policy for corrective action/progressive discipline where needed. We are committed to on-going training of our nursing staff. The D.O.N. met with the P.C.A. staff and nurses to review the medication administration process (Please see attachment "C" Medication Administration Process) and reviewed the M.A.R./T.A.R. auditing process in detail.	2/25/14 & on-going 3/7/14 & on-going

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R128	Continued From page 2 communicate personal choices to staff. 2. Per review of the medical record, Resident #2 was admitted to the facility on 9/27/05 with diagnoses that include hypertension and dementia. Per review of the medication administration record for the month of February 2014, the following routine medications were noted to not have been signed off by staff that the medication was given to Resident #2 per physician's order . Seroquel 50 mg (for dementia) on 2/4, 2/9, 2/15 and 2/16 at 5 PM. Per review of the medication administration record, the nurse's notes, the facility medication error reports and the physician's notes there was no evidence that Resident #2 had refused the medications, or any evidence that there was any reason that Resident #2 should not have received the listed medications as ordered by the physician on 1/28/14. Per review of the facility medication error reports for Resident #2, reports have been issued to nursing staff that pass medications to Resident #2 because the resident did not receive medications on 11/21/13. Per review of the medical record Resident #2 is able to make needs known to staff and communicate personal choices to staff. 3. Per review of the medical record, Resident #3 was admitted to the facility on 7/31/12 with diagnoses that include dementia, seizure disorder and hypertension.	R128	**Resident #2** On 02/20/14 the D.O.N. conducted a follow up investigation regarding Resident #2 medication documentation omissions. A summary of this report is available upon request. The D.O.N. identified that one medication, Seroquel, was omitted by three different P.C.A. staff members. All admitted that these were documentation oversights. Resident #2 is able to make her needs known to the staff and communicate personal choices to staff. All staff members involved have been counseled. Due to the errors that were identified, the organization immediately reviewed all processes and procedures; met with the employees and developed a few new standards of operations. They are as follows: On 02/25/2014 the D.O.N. and Administrator met with all P.C.A. staff and nursing staff members to review the importance of accurate Medication Administration and documentation. We have initiated a daily auditing process per shift (please see attachment "A" M.A.R. and T.A.R Auditing Process and "B" M.A. R. Audit Sheet). The D.O.N. will monitor completed audit forms weekly to ensure the process is being followed. The D.O.N. will address all incomplete audit forms and will follow VCC policy for corrective action/progressive discipline where needed. We are committed to on-going training of our nursing staff.	03/11/14 & on-going 02/25/14 On-going on-going 3/7/14 & on-going

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R128	Continued From page 3 Per review of the medication administration record for the month of February 2014, the following routine medications were noted to not have been signed off by staff that the medication was given to Resident #3 per physician's order . Hydralazine 25 mg (for hypertension) on 2/4, and 2/6 Plavix 75mg (for hypertension) on 2/10 and 2/11. Per review of the medication administration record, the nurse's notes, the facility medication error reports and the physician's notes there was no evidence that Resident #3 had refused the medications, or any evidence that there was any reason that Resident #3 should not have received the listed medications as ordered by the physician on 1/28/14. Per review of the medical record Resident #3 is able to make needs known to staff and communicate personal choices to staff. Per review of the employee files of all medication delegated staff, all medication delegated staff received the appropriate education and follow up from the facility Director of Nursing. Per interview on 2 18/14 with the facility Director of Nursing (DNS) he/she reviewed all the medication administration records, physician orders and nurse's notes and confirmed that there was no evidence that Resident #1, #2 and #3 had received their medications as ordered by their physician on the dates identified above. The DNS confirmed that all staff had been educated regarding medication administration. The DNS confirmed that he/she was not aware of	R128	The D.O.N. met with the P.C.A staff and nurses to review the medication administration process (Please see attachment "C" Medication Administration Process) and reviewed the M.A.R./T.A.R. auditing process in detail. **Resident #3** On 02/20/14 the D.O.N. conducted a follow up investigation regarding Resident #3 medication documentation omissions. A summary of this report is available upon request. The surveyor reported that Hydralazine 25mg and Plavix 75 mg were "noted to not have been signed off by staff that the medication was given to Resident #3." However, the D.O.N. identified that two medications were accurately documented as given, however, the pulses had not been recorded on the M.A.R. per order. All staff involved admitted that these were documentation oversights. Resident #3 is able to make his needs known to the staff and communicate personal choices to staff. All staff members involved have been counseled. Due to the errors that were identified, the organization immediately reviewed all processes and procedures; met with the employees and developed a few new standards of operations. They are as follows: On 02/25/2014 the D.O.N. and Administrator met with all P.C.A. staff and nursing staff members to review the importance of accurate Medication Administration and documentation. We have initiated a daily auditing process per shift (please see attachment "A" M.A.R. and T.A.R Auditing Process and "B" M.A. R. Audit Sheet). The D.O.N. will monitor completed audit forms weekly to ensure the process is being followed.	2/25/14 2/25/14 on-going

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R128	Continued From page 4 the missed medications for the month of February because the unit manager that tracks the medication administration records for missing signatures was away on vacation and the DNS did not have a chance to review the medication records yet. The DNS confirmed that there was no evidence that Resident #1,#2 or #3 had refused to take their medications or had not received there medications for other reasons for the dates identified. The DNS stated that the expectation and facility medication administration policy indicates to staff that if a medication is refused or not given for any reason the medication administration record is to be signed and circled for and on the back of the record as well as in the nurse's notes it should be documented why and the physician be updated. The DNS confirmed that resident's #1,#2 and #3 have the ability to make there choices known to staff. Per interview with the DNS, he/she confirmed after reviewing the last 6 months of medication errors that were addressed, that out of 20 reports made, 14 of them were regarding residents that had medications not given by medication staff .	R128	The D.O.N. will address all incomplete audit forms and will follow VCC policy for corrective action/progressive discipline where needed. We are committed to on-going training of our nursing staff. The D.O.N. met with the P.C.A staff and nurses to review the medication administration process (Please see attachment "C" Medication Administration Process) and reviewed the M.A.R./T.A.R. auditing process in detail.	3/7/14 & on-going

Attachment "A"

M.A.R. and T.A.R. Auditing

Purpose: To have complete and accurate documents of compliance with M.D. orders

Daily Auditing Process Per Shift:

1. The delegated auditor will locate the blank auditing forms in the front of the record binder. Whoever takes the last of the forms is responsible for copying more audit forms to replenish the M.A.R. or T.A.R. for the next shift. Once the employee has finished the audit, she (he) will make copies of those forms and place the copies in an Inter Office Memo envelope located in the D.O.N.'s mailbox. The **original audit forms** will then get dispersed to the staff for them to make necessary corrections. Staff who go off duty prior to the auditing will have their record binder checked by the charge before they are allowed to leave the premises. Additionally, **NO STAFF may leave the premises until all required documentation is completed.** As staff correct the omissions, they sign their initials under the "completed" column. When all corrections have been made, the form is then returned to the charge nurse or med tech. That charge will then place the completed forms in the same Inter Office Memo envelope where the copies were placed, found in the D.O.N.'s mailbox.

2. **It is the responsibility of the charge nurse to delegate which staff will check the M.A.R.s and T.A.R.s on all three shifts.** In the absence of the charge nurse, that responsibility will default to the charge PCA on day shift. Those delegated will find their name posted on the top of page one of the twenty four hour report. When there is enough staff, the auditing task will be divided up. For each shift the audit must be completed in time to allow the staff time to make necessary corrections. That time frame is as follows:

11:00pm-6:00am audit completed by 5:00am

6:00am-2:30pm audit completed by 2:00pm

2:30pm-11:00pm audit completed by 9:30pm

D.O.N. will instruct auditing staff in the types of documentation problems they need to record as follows:

a. Un-initialed boxes with or without circles

b. Boxes that say "unavailable" without explanation for why med or resident unavailable.

Acceptable documentation for the unavailability of a med or a resident would be noted on the reverse side of the M.A.R. and/or in a nurse's note. This documentation might include things like:

(OVER)

- Resident refused and written reason why resident refused. Also, please refer to page 76 of VCC Residential Care Home Policy Book about med refusal.
- Resident out of building (hospital, out to lunch, etc.)
- Med unavailable reason with a notation that D.O.N./Triage nurse was notified
- Med held per M.D. orders

Every week the D.O.N. will collect and review the audit forms.

Revised 3/5/14

ATTACHMENT "B"

M.A.R./T.A.R. Audit Sheet

Missed Documentation Sheet

Staff with Missed Documentation:______________________________

Date	Resident Name	Book	Problem	Completed (Please Initial)

ATTACHMENT "C"

Medication Administration Process

Purpose:

To ensure that the staff person assigned to give medications see that the "right dose" of the "right drug" is given to the "right person" at the right time" by the "right method".

Process:

A quiet, orderly, well-lighted preparation area is necessary to prevent drug errors while pouring Medications. The time spent pouring medications should be free from interruptions to prevent drug errors.

1. Wash Hands
2. Assemble equipment, such as:
   - Medication administration record, also known as MAR
   - Medication cart.
   - Disposable medication cups with medication cup labels; paper for tablets and capsules; waxed or plastic calibrated cups for liquids.
   - Liquids and soft food, such as applesauce or pudding, if necessary, to facilitate swallowing whole tablets/capsules or for crushed medications.
3. Read the MAR and take the appropriate medication from its storage area.
4. Compare the label of the medication container against the MAR. If there are any discrepancies, check the original order. **If discrepancies remain, contact the registered nurse.**
5. Prepare the correct amount of medication for the required dose, without contaminating the medication.

   a. When administering tablets or capsules, pour the correct number into the bottle cap (do not handle the medication with your fingers) and then transfer the medication to the paper cup. Generally, all tablets/capsules to be given the same time are placed in the same cup UNLESS specific measurements, ex. pulse, BP, respirations, need to be obtained prior to administration of a medication. Those medications must be kept separate from the other medications.

   b. When administering liquid medications, read label to determine if shaking is necessary to evenly disperse the medication throughout the liquid. Remove the bottle cap and place upside down to avoid contaminating it. Hold the bottle with label against your palm so that the label will not become soiled of illegible if medication is spilled. Hold the medication cup at eye level and fill it to the desired level.

6. Check the label on the container again and return the container to its storage place.

7. Continue in this manner until all medications are prepared. Note: If using a unit dose system and/or medication cart, generally each resident's-medication is prepared and administered and documented before continuing on to the next resident
    a. Identify the appropriate resident to whom medication will be administered. Call the resident by name before giving medication. **If unsure who resident is, ask resident to state their name.**
    b. Take the required assessment measures, ex. pulse, BP, respirations if necessary. Give the medication; STAYING WITH the resident to make sure the medication is consumed.
    c. Give the resident sufficient fluids to swallow the medication if appropriate. If giving medication with food, use only a small amount (ex. pudding, ice cream, and yogurt) on a spoon. Never mix medication with the food on a resident's plate or tray.
    d. Document the medications given, withheld or refused.
    e. If PRN medications were administered, return to the resident within 30-60 minutes to note effects of the medication, ex. relief of pain, and document.
8. At the beginning of the medication pass while going page by page, if you see a place where you will have an unfinished task, place a straw in the MAR to help remind you that you still have part of a task to do. For example: documentation of the pulse, blood pressure, or blood sugar. Additionally, the straw can serve as a reminder that residents have off hour medications due. Furthermore, this method is a helpful reminder of inhalers, nebulizer treatments and eye drops that are due but may not be able to be given when passing pills.

Review of the five RIGHTS

- RIGHT DRUG: To ensure the right medication, the staff person should read the label on the bottle three times. First, when the bottle or blister pack is taken from the shelf or drawer. Second, when the medication is poured from the bottle or blister pack. Third, when the bottle or blister pack is replaced on the shelf or in the drawer.

- RIGHT DOSAGE: To insure giving the right dosage, check the Medication Record with the label to see if the dosage is the same as ordered. **If you are uncertain, check with the nurse or practitioner.** Use the proper equipment for measuring the medication.

- RIGHT CLIENT: To insure the right client, check the name on the medication bottle with the client to whom you are giving the medication. If you are not familiar with the individual clients another staff person who knows each client should be with you while you give out the medication.

- RIGHT METHOD: To insure the right method, check the medication bottle and record and give according to directions. Some of the labels will also tell how a medication is to be given. **If you have any doubts, ask the practitioner or pharmacist or nurse.**

- RIGHT TIME: To insure the right time, give medications within 60 minutes of time for which it is ordered. If the dose is missed, do not double the next dose.

Revised 3/7/14